TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael P. McGarrah, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3067-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Regarding the charge for 99456 W5 WP the charge was $650 – the amount paid was $500.00… We do not fall under the Worker's Compensation Fee Schedule…

Texas Labor Code 413.011 and 413.015 and Chapter 133 of the Division's Rules require an insurance carrier to make appropriate payment of charges for medical services in accordance with the Division's fee guidelines and medical policies."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $650.00 for MMI/IR exams. Texas Mutual paid $350.00 for the MMI exam and $150.00 for the IR exam. However, the requestor wants to be paid $300.00 for an IR exam of a non-musculoskeletal area, i.e. inguinal hernia. Texas Mutual does not agree per Rule 133.204(j)(4)(D)(v)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2014	Designated Doctor Examination (MMI/IR/EOI)	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guidelines for Workers' Compensation Specific Services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-18 – Exact duplicate claim/service
   - 224 – Duplicate charge
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. What are the correct rules for review of the disputed services?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. In their position statement, the requestor claims that they "do not fall under the Worker's Compensation Fee Schedule." In addition, Texas Mutual points to "Rule 133.204(j)(4)(D)(v)" regarding the reason for reduction. However, 28 Texas Administrative Code §134.204 (i) states, "The following shall apply to Designated Doctor Examinations." Review of the submitted documentation finds that the dispute involves charges from a designated doctor examination. Therefore, the correct rules to review the dispute are found in 28 Texas Administrative Code §134.204 (i)-(n).

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   28 Texas Administrative Code §134.204(j)(4)(D) states, "(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides… (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150". Review of the submitted documentation finds that the requestor performed impairment rating evaluation of an inguinal hernia. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places this injury in the Digestive System chapter (p. 247). For this reason, it is considered a body system in the non-musculoskeletal category. Therefore, the correct MAR for this examination is $150.00.

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Therefore, the correct MAR for this examination is $500.00.

3. The total allowable for the disputed services is $1000.00. The insurance carrier paid $1000.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	June 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.